STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING _____ B. WING _____	R-C 07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	**181 CAMPUS DR LAWRENCEBURG, IN 47025**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00148924 and IN00148977 completed on 5/20/2014.

This visit was in conjunction with a PSR to the Investigation of Complaint IN00146881 completed on 4/9/2014.

Complaint IN00148924 - Corrected.
Complaint IN00148977 - Corrected.

Survey dates: June 30 and July 1, 2014

Facility number: 012523
Provider number: 155789
AIM number: 201027870

Survey team:
Jennifer Carr, RN - TC
Angela Halcomb, RN (July 1, 2014)

Census bed type:
SNF/NF: 43
Residential: 44
Total: 87

Census payor type:
Medicare: 20
Medicaid: 23
Other: 44
Total: 87

Sample: 3
Residential Sample: 3

Ridgewood Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING _____ B. WING _____	R-C 07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	**181 CAMPUS DR LAWRENCEBURG, IN 47025**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 410 IAC 16.2-3.1, in regard to the PSR to the Investigation of Complaints IN00148924 and IN00148977. Quality Review completed on July 8, 2014, by Brenda Meredith, R.N.	{F 000}		